BEFORE THE BOARD OF COUNTY COMMISSIONERS

OF LEWIS COUNTY, WASHINGTON

MEDICAL RATES TO BE PAID BY LEWIS COUNTY FOR NON-UNION EMPLOYEES FOR 2005	)))	RESOLUTION NO. 04- 385

WHEREAS, Washington Counties Insurance Fund (WCIF) rates for medical and dental coverage for employees covered under WCIF plans will increase for 2005; and,

WHEREAS, the employer's contribution for non-union employees covered by the WCIF plans will be funded at the WCIP Budget PPO at 95% of employee premium costs and 75% for spouse/dependents premium costs. The attached sheets show employer and employee contributions for the 2005 plan year; **NOW THEREFORE**

BE IT HEREBY RESOLVED that Lewis County will adopt the following medical rates for 2005 for full and eligible part-time county positions not covered by collective bargaining units as listed on the attached Exhibits A and B, and incorporated by reference into this resolution.

DONE IN OPEN SESSION this 6 day of ~~November~~ December, 2004.

BOARD OF COUNTY COMMISSIONERS
LEWIS COUNTY WASHINGTON

Chairman

Member

Member

ATTEST:

Clerk of the Board

2005 WCIP MEDICAL & WA DENTAL SERVICE INSURANCE RATES

		2005 Premium	Employer Paid	Employee Paid	
WCIP NEW STANDARD PPO					
	Employee Medical	486.66	410.25	76.41	
	Spouse Medical	486.66	297.42	265.65	*
	One Child Medical	190.54	133.16	133.79	*
	Children Medical	333.46	233.01	176.86	*
	Spouse + 1 Child Medical	677.20	430.58	323.03	*
	Spouse + Children Medical	820.12	530.43	366.10	*
		*Employee Paid amount includes $76.41 Employee Medical			
WA Dental Service	*Employee/Dependent Composite*	93.48	93.48	0.00	
WCIP BUDGET PPO					
	Employee Medical	$437.80	410.25	27.55	
	Spouse Medical	396.56	297.42	126.69	*
	One Child Medical	177.54	133.16	71.93	*
	Children Medical	310.68	233.01	105.22	*
	Spouse + 1 Child Medical	574.10	430.58	171.07	*
	Spouse + Children Medical	707.24	530.43	204.36	*
		*Employee Paid amount includes $27.55 Employee Medical			
WA Dental Service	*Employee/Dependent Composite*	93.48	93.48	0.00	
WCIP Value PPO					
	Employee Medical	399.53	399.53	0.00	
	Spouse Medical	361.90	297.42	64.48	
	One Child Medical	162.03	133.16	28.87	
	Children Medical	283.53	233.01	50.52	
	Spouse + 1 Child Medical	523.93	430.58	93.35	
	Spouse + Children Medical	645.43	530.43	115.00	
WA Dental Service	*Employee/Dependent Composite*	93.48	93.48	0.00	
WCIP AffOURable Plan					
	Employee Medical	319.62	319.62	0.00	
	Spouse Medical	289.53	289.53	0.00	
	One Child Medical	129.62	129.62	0.00	
	Children Medical	226.83	226.83	0.00	
	Spouse + 1 Child Medical	419.15	419.15	0.00	
	Spouse + Children Medical	516.36	516.36	0.00	
WA Dental Service	*Employee/Dependent Composite*	93.48	93.48	0.00	
BUDGET OPTIONS (FORMERLY GROUP HEALTH)					
	Employee Medical	432.53	410.25	22.28	
	Spouse Medical	432.53	297.42	157.39	*
	One Child Medical	235.70	133.16	124.82	*
	Children Medical	471.88	233.01	261.15	*
	Spouse + 1 Child Medical	668.23	430.58	259.93	*
	Spouse + Children Medical	904.41	530.43	396.26	*
		*Employee Paid amount includes $22.28 Employee Medical			
WA Dental Service	*Employee/Dependent Composite*	93.48	93.48	0.00	
OPTIONS SELECT - $200 deductible (FORMERLY GROUP HEALTH)					
	Employee Medical	387.12	387.12	0.00	
	Spouse Medical	387.12	297.42	89.70	*
	One Child Medical	210.96	133.16	77.80	*
	Children Medical	422.36	233.01	189.35	*
	Spouse + 1 Child Medical	598.08	430.58	167.50	*
	Spouse + Children Medical	809.48	530.43	279.05	*
WA Dental Service	*Employee/Dependent Composite*	93.48	93.48	0.00	
VISION SERVICE PLAN					
	Employee/Dependent Composite	15.07	15.07	0.00	
LIFE INSURANCE ($12,000 Employee)					
	Employee Life	1.80	1.80	0.00	
	Dependent Life	0.65	0.00	0.65	
EMPLOYEE HEALTH & ACCIDENT					
	Employee only	2.85	2.85	0.00	

	Washington Counties Insurance Pool					
	PPO				Options Budget	Options Select - 200
	New Standard	Budget	Value	AlFOURdable	Inside Network	Inside Network Only
Alternative Care	Alternative Care must be medically necessary. Naturopaths treated as any other provider. Acupuncturists limited to 12 visits; none for obesity or smoking cessation. Massage Therapy must be prescribed by a medical doctor; (some restrictions apply) Chiropractic Care defined in Chiropactic Section of Benefit Summary. All services subject to applicable copays and coinsurance.		$500 annual maximum for Alternative Care. Alternative Care must be medically necessary. Naturopaths treated as any other provider. Acupuncturists limited to 12 visits; none for obesity or smoking cessation. Massage Therapy must be prescribed by a medical doctor. Chiropractic Care defined in Chiropactic Section.All services subject to applicable copays, deductibles and coinsurance		Acupuncture 5 self referral visits then need PCP referral; Naturopathy 2 self referral visits then need PCP referral; Massage Therapy must be referred by PCP, covered only for specified conditions, subject to $15 copay. See Chiropractic Care Section.	Acupuncture 5 self referral visits then need PCP referral; Naturopathy 2 self referral visits then need PCP referral; Massage Therapy must be referred by PCP, covered only for specified conditions, subject to annual deductible & $15 copay. See Chiropractic Care Section.
Chiropractic Care	100% after $20 copay up to 12 visits per year; 100% for x rays	80% after $20 copay up to 12 visits per year, 80% for x-rays	80%, after $20 copay and deductible; up to 12 visits per year, 80% for x-rays	100% after $20 copay first 4 visits, then 80% after deductible, see diagnostic x-ray, lab for x-rays	10 visits per calendar year; $15 copay per visit	10 visits per calendar year. Subject to annual deductible, then $15 copay per visit
Co-Insurance	Percentage varies based on provider and type of service; $1,000 annual out-of-pocket per person; $2,000 annual out-of-pocket per family	Percentage varies based on provider and type of service; $1,500 annual out-of-pocket per person; $3,000 annual out-of-pocket per family	Percentage varies based on provider and type of service; $1,750 annual out-of-pocket per person; $3,500 annual out-of-pocket per family;	Percentage varies based on provider and type of service; $5,000 annual out-of-pocket per person; $10,000 annual out-of-pocket per family;	$2,000 annual out-of-pocket per person; $4,000 annual out-of-pocket per family	$2,000 annual out-of-pocket per person; $6,000 annual out-of-pocket per family
Deductible/Copays	No deductibles; $20 office visit copay; Copays do not apply to annual out of pocket maximum		Deductible $200 per person/$600 per family; $20 office visit copay. Deductible and copay do not apply to annual out of pocket maximum.	Deductible $500 per person/$1000 per family; $20 office visit copay. Deductible and copay do not apply to annual out of pocket maximum.	No deductibles/see copays below	Deductible $200 member; $600 family see copays below
Diabetes Management **Special Benefit**	80% for the services of an approved diabetes training facility to a lifetime maximum of $300; the facility is approved if it qualifies under the Medicare Act; coverage under this benefit is not applied to the co-insurance limit; subject to copay		80% after deductible for the services of an approved diabetes training facility to a lifetime maximum of $300; the facility is approved if it qualifies under the Medicare Act; coverage under this benefit is not applied to the co-insurance limit; subject to copays and deductible		100% after $15 copay per visit	Subject to annual deductible, then 100% after $15 copay per visit
Diagnostic, X-Ray, Lab	100% for PPO doctor or lab with $20 copay;90% for hospital lab; 60% for non-PPO Provider	80% for PPO doctor or lab with $20 copay; 80% for hospital lab; 50% for non-PPO Provider	80% for PPO doctor or lab after $20 copay and deductible; 80% for hospital lab after deductible; 50% for non-PPO Provider	100% for PPO doctor or lab after $20 copay, first $500 per member; then 80% after $20 copay and deductible; 50% for non PPO Provider	100%	Subject to annual deductible, then 100%
Emergency Room (Life Threatening)	Must be life or limb threatening. 90% after $75 copay for PPO; 60% after $75 copay for non-PPO; copay waived if admitted to hospital	Must be life or limb threatening. 80% after $75 copay for PPO; 50% after $75 copay for non-PPO; copay waived if admitted to hospital	Must be life or limb threatening. 80% after $75 copay and deductible for PPO; 50% after $75 copay and deductible for non-PPO; copay waived if admitted to hospital	Must be life or limb threatening. 80% after $100 copay for PPO; 50% after $100 copay for non-PPO; copay waived if admitted to hospital	100% after $75 copay at Option Network Facility	100% after $75 copay at Options Network Facility, $125 deductible at Non-Options Network Facility.
Eye Examination	100% after $20 copay once in 12 months; 60% after $20 copay for non-PPO	80% after $20 copay once in 12 months; 50% after $20 copay for non-PPO	80% after $20 copay & deductible once in 12 months; 50% after $20 copay & deductible for non-PPO	See Office Visit	100% after $15 copay per year	100% after $15 copay per year. Not subject to annual deductible
Hospital Room & Board	90% of semi-private room rate for PPO; Pre-Admission approval required; 60% for non -PPO	80% of semi-private room rate for PPO; Pre-Admission approval required; 50% for non-PPO	80% of semi-private room rate after deductible for PPO; Pre-Admission approval required; 50% after deductible for non-PPO	80% of semi-private room rate after deductible for PPO; Pre-Admission approval required; 50% after deductible for non-PPO	$100 per day copay to maximum of $500 per member annually	Subject to annual deductible, then 100%
Hospital Misc. Expenses	90%	80%	80%	80%	100%	Subject to annual deductible, then 100%
Intensive Care	90% for PPO ; Pre-Admission approval required; 60% for non-PPO Provider	80% for PPO; Pre-Admission approval required; 50% for non-PPO Provider	80% for PPO subject to deductible; Pre-Admission approval required; 50% after deductible for non-PPO Provider		100%	Subject to annual deductible, then 100%
Mammograms	100%				100%	Subject to annual deductible, then 100%
Office Visit	100% after $20 copay for PPO; 60% after $20 copay for non-PPO; no copays for allergy shots	80% after $20 copay for PPO; 50% after $20 copay for non-PPO; no copays for allergy shots	80% after $20 copay and deductible for PPO; 50% after $20 copay and deductible for non-PPO; no copays for allergy shots	100% after $20 copay for first 4 visits for PPO, then 80% after $20 copay and deductible; no copays for allergy shots	100% after $15 copay	Subject to annual deductible, then 100% after $15 copay
Prescription Drugs (Participating Pharmacies)	**Retail Pharmacy 10/18/50% Mail Order 25/45/50%** **FORMULARY DRUG PLAN** Retail $10 generic, $18 brand name formulary, 50% non-formulary for 30 day supply; Mail Order $25 generic, $45 brand name formulary, 50% non-formulary for 90 day supply;			**50%** **FORMULARY DRUG PLAN** Retail 50% generic, brand name, and non-preferred brand name; Mail order 50% for 90 day supply all drugs	30 day supply subject to $10 copay	30 day supply subject to $10 generic / $20 brand copay. Not subject to deductible. 90 day mail order available for maintenance drugs with $20 generic/ $40 brand copay. Not subject to deductible.
Routine Physical Examination	$300 once per year after $20 copay per visit; 60% benefits for non-PPO; includes Well Baby care. Also covers CDL physicals for Public Works employees and Bus Drivers only.	$300 once per year after $20 copay per visit; 50% benefits for non-PPO; includes Well Baby care. Also covers CDL physicals for Public Works employees and Bus Drivers only.	Well Baby Care Only $20 office visit copay Deductible does not apply	$500 once per year benefit covered in full after $20 office visit copay. Does not apply to 4 visit limit. Deductible does not apply.	100% after $15 copay	100% after $15 copay Not subject to annual deductible
Well Baby Care	Included in routine physical after $20 copay	Included in routine physical after $20 copay	$300 per year after $20 copay per visit; 50% benefits for non-PPO, deductible doe not apply	$500 per year benefit covered in full after $20 office visit copay. Does not apply to 4 visit limit. Deductible does not apply.	100% after $15 copay	$15 copay, then 100%. Not subject to annual deductible

2005 WCIP MEDICAL & WILLAMETTE DENTAL INSURANCE RATES

		2005 Premium	Employer Paid	Employee Paid	
WCIP NEW Standard PPO					
	Employee Medical	486.66	464.74	21.92	
	Spouse Medical	486.66	273.06	235.52	*
	One Child Medical	190.54	108.80	103.66	*
	Children Medical	333.46	152.01	203.37	*
	Spouse + 1 Child Medical	677.20	349.58	349.54	*
	Spouse + Children Medical	820.12	449.43	392.61	*
Willimette Dental	*Employee Dental*	38.99	38.99	0.00	
	Employee + 1 Dependent Dental	63.35	63.35	0.00	
	Employee + 2 or More Dependents	119.99	119.99	0.00	
Dental Premium F	*Employee + 1 Dependent Dental*	63.35	38.99	24.36	
	Employee + 2 or More Dependents	119.99	38.99	81.00	
WCIP BUDGET PPO					
	Employee Medical	437.80	$437.80	$0.00	
	Spouse Medical	396.56	300.00	96.56	
	One Child Medical	177.54	135.74	41.80	
	Children Medical	310.68	178.95	131.73	
	Spouse + 1 Child Medical	574.10	376.52	197.58	
	Spouse + Children Medical	707.24	476.37	230.87	
Willimette Dental	*Employee Dental*	38.99	38.99	0.00	
	Employee + 1 Dependent Dental	63.35	63.35	0.00	
	Employee + 2 or More Dependents	119.99	119.99	0.00	
Dental Premium For Employee with Medical coverage only:					
	Employee + 1 Dependent Dental	63.35	63.35	0.00	
	Employee + 2 or More Dependents	119.99	65.93	54.06	
WCIP VALUE PPO					
	Employee Medical	399.53	399.53	0.00	
	Spouse Medical	361.90	338.27	23.63	
	One Child Medical	162.03	162.03	0.00	
	Children Medical	283.53	217.22	66.31	
	Spouse + 1 Child Medical	523.93	414.79	109.14	
	Spouse + Children Medical	645.43	514.64	130.79	
Willimette Dental	*Employee Dental*	38.99	38.99	0.00	
	Employee + 1 Dependent Dental	63.35	63.35	0.00	
	Employee + 2 or More Dependents	119.99	119.99	0.00	
Dental Premium For Employee with Medical coverage only:					
	Employee + 1 Dependent Dental	63.35	63.35	0.00	
	Employee + 2 or More Dependents	119.99	104.20	15.79	

		2005 Premium	Employer Paid	Employee Paid
WCIP AffOURdable Plan				
	Employee Medical	319.62	319.62	0.00
	Spouse Medical	289.53	289.53	0.00
	One Child Medical	129.62	129.62	0.00
	Children Medical	226.83	226.83	0.00
	Spouse + 1 Child Medical	419.15	419.15	0.00
	Spouse + Children Medical	516.36	516.36	0.00
Willimette Dental	*Employee Dental*	38.99	38.99	0.00
	Employee + 1 Dependent Dental	63.35	63.35	0.00
	Employee + 2 or More Dependents	119.99	119.99	0.00
Dental Premium For Employee with Medical coverage only:				
	Employee + 1 Dependent Dental	63.35	63.35	0.00
	Employee + 2 or More Dependents	119.99	119.99	0.00
BUDGET OPTIONS (FORMERLY GROUP HEALTH)				
	Employee Medical	432.53	432.53	0.00
	Spouse Medical	432.53	305.27	127.26
	One Child Medical	235.70	141.01	94.69
	Children Medical	471.88	184.22	287.66
	Spouse + 1 Child Medical	668.23	381.79	286.44
	Spouse + Children Medical	904.41	481.64	422.77
Willimette Dental	*Employee Dental*	38.99	38.99	0.00
	Employee + 1 Dependent Dental	63.35	63.35	0.00
	Employee + 2 or More Dependents	119.99	119.99	0.00
Dental Premium For Employee with Medical coverage only:				
	Employee + 1 Dependent Dental	63.35	63.35	0.00
	Employee + 2 or More Dependents	119.99	71.20	48.79
OPTIONS SELECT - $200 deductible (FORMERLY GROUP HEALTH)				
	Employee Medical	387.12	387.12	0.00
	Spouse Medical	387.12	350.68	36.44
	One Child Medical	210.96	186.42	24.54
	Children Medical	422.36	229.63	192.73
	Spouse + 1 Child Medical	598.08	427.20	170.88
	Spouse + Children Medical	809.48	527.05	282.43
Willimette Dental	*Employee Dental*	38.99	38.99	0.00
	Employee + 1 Dependent Dental	63.35	63.35	0.00
	Employee + 2 or More Dependents	119.99	119.99	0.00
Dental Premium For Employee with Medical coverage only:				
	Employee + 1 Dependent Dental	63.35	63.35	0.00
	Employee + 2 or More Dependents	119.99	116.61	3.38
VISION SERVICE PLAN				
	Employee/Dependent Composite	15.07	15.07	0.00
LIFE INSURANCE ($12,000 Employee)				
	Employee Life	1.80	1.80	0.00
	Dependent Life	0.65	0.00	0.65
EMPLOYEE HEALTH & ACCIDENT				
	Employee only	2.85	2.85	0.00

	Washington Counties Insurance Pool					
	PPO				Options Budget	Options Select - 200
	New Standard	Budget	Value	AFFORDable	Inside Network	Inside Network Only
Alternative Care	Alternative Care must be medically necessary. Naturopaths treated as any other provider. Acupuncturists limited to 12 visits; none for obesity or smoking cessation. Massage Therapy must be prescribed by a medical doctor; (some restrictions apply) Chiropractic Care defined in Chiropractic Section of Benefit Summary. All services subject to applicable copays and coinsurance.		$500 annual maximum for Alternative Care. Alternative Care must be medically necessary. Naturopaths treated as any other provider. Acupuncturists limited to 12 visits; none for obesity or smoking cessation. Massage Therapy must be prescribed by a medical doctor. Chiropractic Care defined in Chiropractic Section.All services subject to applicable copays, deductibles and coinsurance		Acupuncture 5 self referral visits then need PCP referral; Naturopathy 2 self referral visits then need PCP referral; Massage Therapy must be referred by PCP, covered only for specified conditions, subject to $15 copay. See Chiropractic Care Section.	Acupuncture 5 self referral visits then need PCP referral; Naturopathy 2 self referral visits then need PCP referral; Massage Therapy must be referred by PCP, covered only for specified conditions, subject to annual deductible & $15 copay. See Chiropractic Care Section.
Chiropractic Care	100% after $20 copay up to 12 visits per year; 100% for x-rays	80% after $20 copay up to 12 visits per year, 80% for x-rays	80%, after $20 copay and deductible; up to 12 visits per year; 80% for x-rays	100% after $20 copay first 4 visits, then 80% after deductible, see diagnostic x-ray, lab for x-rays	10 visits per calendar year; $15 copay per visit	10 visits per calendar year. Subject to annual deductible, then $15 copay per visit
Co-Insurance	Percentage varies based on provider and type of service; $1,000 annual out-of-pocket per person; $2,000 annual out-of-pocket per family	Percentage varies based on provider and type of service; $1,500 annual out-of-pocket per person; $3,000 annual out-of-pocket per family	Percentage varies based on provider and type of service; $1,750 annual out-of-pocket per person; $3,500 annual out-of-pocket per family;	Percentage varies based on provider and type of service; $5,000 annual out-of-pocket per person; $10,000 annual out-of-pocket per family;	$2,000 annual out-of-pocket per person; $4,000 annual out-of-pocket per family	$2,000 annual out-of-pocket per person; $6,000 annual out-of-pocket per family
Deductible/Copays	No deductibles; $20 office visit copay; Copays do not apply to annual out of pocket maximum		Deductible $200 per person/$600 per family; $20 office visit copay. Deductible and copay do not apply to annual out of pocket maximum.	Deductible $500 per person/$1000 per family; $20 office visit copay. Deductible and copay do not apply to annual out of pocket maximum.	No deductibles/see copays below	Deductible $200 member; $600 family see copays below
Diabetes Management Special Benefit	80% for the services of an approved diabetes training facility to a lifetime maximum of $300; the facility is approved if it qualifies under the Medicare Act; coverage under this benefit is not applied to the co-insurance limit; subject to copay		80% after deductible for the services of an approved diabetes training facility to a lifetime maximum of $300; the facility is approved if it qualifies under the Medicare Act; coverage under this benefit is not applied to the co-insurance limit; subject to copays and deductible		100% after $15 copay per visit	Subject to annual deductible, then 100% after $15 copay per visit
Diagnostic, X-Ray, Lab	100% for PPO doctor or lab with $20 copay;80% for hospital lab; 60% for non-PPO Provider	80% for PPO doctor or lab with $20 copay; 80% for hospital lab; 50% for non-PPO Provider	80% for PPO doctor or lab after $20 copay and deductible; 80% for hospital lab after deductible; 60% for non-PPO Provider	100% for PPO doctor or lab after $20 copay, first $300 per member; then 80% after $20 copay and deductible; 80% for non PPO Provider	100%	Subject to annual deductible, then 100%
Emergency Room (Life Threatening)	Must be life or limb threatening. 80% after $75 copay for PPO; 60% after $75 copay for non-PPO; copay waived if admitted to hospital	Must be life or limb threatening. 80% after $75 copay for PPO; 50% after $75 copay for non-PPO; copay waived if admitted to hospital	Must be life or limb threatening. 80% after $75 copay and deductible for PPO; 50% after $75 copay and deductible for non-PPO; copay waived if admitted to hospital	Must be life or limb threatening. 80% after $100 copay for PPO; 50% after $100 copay for non-PPO; copay waived if admitted to hospital	100% after $75 copay at Option Network Facility	100% after $75 copay at Options Network Facility, $125 deductible at Non-Options Network Facility.
Eye Examination	100% after $20 copay once in 12 months; 80% after $20 copay for non-PPO	80% after $20 copay once in 12 months; 50% after $20 copay for non-PPO	80% after $20 copay & deductible once in 12 months; 50% after $20 copay & deductible for non-PPO	See Office Visit	100% after $15 copay per year	100% after $15 copay per year, Not subject to annual deductible
Hospital Room & Board	90% of semi-private room rate for PPO; Pre-Admission approval required; 60% for non -PPO	80% of semi-private room rate for PPO; Pre-Admission approval required; 50% for non-PPO	80% of semi-private room rate after deductible for PPO; Pre-Admission approval required; 50% after deductible for non-PPO	80% of semi-private room rate after deductible for PPO; Pre-Admission approval required; 50% after deductible for non-PPO	$100 per day copay to maximum of $500 per member annually	Subject to annual deductible, then 100%
Hospital Misc. Expenses	90%	80%	80%	50%	100%	Subject to annual deductible, then 100%
Intensive Care	90% for PPO ; Pre-Admission approval required; 60% for non-PPO Provider	80% for PPO; Pre-Admission approval required; 50% for non-PPO Provider	80% for PPO subject to deductible; Pre-Admission approval required; 50% after deductible for non-PPO Provider		100%	Subject to annual deductible, then 100%
Mammograms	100%				100%	Subject to annual deductible, then 100%
Office Visit	100% after $20 copay for PPO; 60% after $20 copay for non-PPO; no copays for allergy shots	80% after $20 copay for PPO; 50% after $20 copay for non-PPO; no copays for allergy shots	80% after $20 copay and deductible for PPO; 50% after $20 copay and deductible for non-PPO; no copays for allergy shots	100% after $20 copay for first 4 visits for PPO, then 80% after $20 copay and deductible; no copays for allergy shots	100% after $15 copay	Subject to annual deductible, then 100% after $15 copay
Prescription Drugs (Participating Pharmacies)	Retail Pharmacy 10/15/60%. Mail Order 25/45/50% FORMULARY DRUG PLAN Retail $10 generic, $18 brand name formulary, 50% non-formulary for 30 day supply; Mail Order $25 generic, $45 brand name formulary, 50% non-formulary for 90 day supply;			80% FORMULARY DRUG PLAN Retail 50% generic, brand name, and non-preferred brand name; Mail order 50% for 90 day supply all drugs	30 day supply subject to $10 copay	30 day supply subject to $10 generic / $20 brand copay. Not subject to deductible. 90 day mail order available for maintenance drugs with $20 generic/ $40 brand copay. Not subject to deductible.
Routine Physical Examination	$300 once per year after $20 copay per visit; 60% benefits for non-PPO; Includes Well Baby care. Also covers CDL physicals for Public Works employees and Bus Drivers only.	$300 once per year after $20 copay per visit; 50% benefits for non-PPO; Includes Well Baby care. Also covers CDL physicals for Public Works employees and Bus Drivers only.	Well Baby Care Only $20 office visit copay Deductible does not apply	$500 once per year benefit covered in full after $20 office visit copay. Does not apply to 4 visit limit. Deductible does not apply.	100% after $15 copay	100% after $15 copay Not subject to annual deductible
Well Baby Care	Included in routine physical after $20 copay	Included in routine physical after $20 copay	$300 per year after $20 copay per visit; 50% benefits for non-PPO, deductible doe not apply	$300 per year benefit covered in full after $20 office visit copay. Does not apply to 4 visit limit. Deductible does not apply.	100% after $15 copay	$15 copay, then 100%. Not subject to annual deductible

BOCC AGENDA ITEM SUMMARY

(revised 5-17-01)

AGENDA ITEM #: _____ **RESOLUTION #:** _____ **BOCC MEETING DATE:** 12-6-04

SUGGESTED WORDING FOR AGENDA ITEM: ☐ Notice ☒ Consent ☐ Discussion ☐ Hearing

Medical rates to be paid by L.C. for non-union employees for 2005

BRIEF REASON FOR BOCC ACTION:

SUBMITTED BY: BOCC **PHONE:** * 1120 **DATE SUBMITTED:** 11-23-04

CONTACT PERSON WHO WILL ATTEND BOCC MEETING: _____

TYPE OF ACTION NEEDED:

- ☒ Approve Resolution
- ☐ Approve Ordinance (Traffic or other)
- ☐ Execute Contract / Agreement
- ☐ Other *(please describe):* _____
- ☐ Call for Bids / Proposals
- ☐ Bid Opening
- ☐ Notice for Public Hearing **(see Publication Requirements)*

***PUBLICATION REQUIREMENTS:** ☐ Resolution e-mailed to Clerk ☐ Not applicable

Hearing Date: _____ *(Must be at least 10 days after first publication date)*

Publish Date(s): _____ *(2 weeks for routine budget, property disposal / auction or vacations)* *(3 weeks for property lease)*

Publication(s): ☐ *EAST COUNTY JOURNAL* ☐ *CHRONICLE* ☐ *OTHER:* _____

ALL AGENDA ITEMS:
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Chief Administrative Officer: _____
Prosecuting Attorney: _____

EMPLOYEE ITEMS: (relating to employment, salary, position, reclassification, union, etc.)
Human Resource Coordinator: _____ _____

BANKING OR REVENUE ITEMS:
Treasurer: _____

BUDGET AND PAYROLL ITEMS:
Chief Accountant: _____ _____

Fund: _____
Department: _____
Total Amount: $ _____

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